APPLICATION FOR FACILITY LICENSE

(See attached page for instructions)

Reply to:

FOR DEPARTMENT USE ONLY

District: _____ Facility Number: _____

Date: _____ Action Type: _____

Reviewed by: _____ Facility Type: _____

1. Applicant(s) Name(s)

2. Check Type:
   - ❒ a. Individual ❒ b. Partnership ❒ c. Nonprofit Corporation ❒ d. Limited Liability Company
   - ❒ e. Profit Corporation ❒ f. County ❒ g. Other Public Agency ❒ h. Federal Employer's Tax ID No.: _____

3. Applicant Address	City	State	ZIP Code	Telephone Number

4. Facility (or Agency) Name

5. Facility Location	City	State	ZIP Code	Telephone Number

6. Facility Mailing Address (if different)	City	State	ZIP Code

7. Name of Person in Charge of Facility	Title	License Number (if applicable)

8. Type of Application:
   - ❒ a. New Application ❒ b. Change of Capacity ❒ c. Change of Location
   - ❒ d. Change of Services ❒ e. Change of Facility Type ❒ f. Change of Ownership
   - ❒ g. Change of Bed Classification ❒ h. Other Change (Specify) _____

9. Type of Facility (or Agency)	10. Amount of Fee Enclosed

11. Requested Capacity	12. Age Range of Clients	13. Time of Operation

14. Was Facility Previously Licensed?
   - ❒ Yes If Yes, Facility Number: _____
   - ❒ No Licensing Agency: _____

15. Is Major Construction Required?	Date Construction to Begin:	Date to be Completed:	16. Property Ownership:
❒ Yes ❒ No			❒ Own ❒ Other (specify): _____ ❒ Rent

17. List persons with five percent or more facility ownership interest and share owned by each individual if applying for skilled nursing or intermediate care licensure and ten percent for all other facilities. Provide Federal Employer's Tax ID number.

18. List name and address of any person or organizations listed as owner of record in the real estate, lessors or sublessors, including the buildings and the grounds appurtenant to the buildings.

19. What other facilities, clinics, home health agencies, or community care facilities has applicant been licensed for, operated, managed, held a five percent or more interest in, or served as a director or officer? List facility address, nature of involvement, and dates of involvement on attachment. Include facilities both in and outside of California.

20. Has the applicant ever been a licensee, director, officer, manager, or held a five percent interest in a health facility, clinic, home health agency, or community care facility in any state or as an applicant for any other licensing category held a ten percent or more interest, or been a member of the governing body, director, or administrator of any health facility, community care facility, or residential care facility for the elderly which has had a license revocation filed, license placed on probation, suspended, revoked, whether stayed or not, or license action resolved by settlement or receiver appointed or where a final Medi-Cal decertification action was taken?

   ❒ Yes ❒ No

21. If the applicant or licensee is a subsidiary of another organization, include the names, addresses, and Federal Employer's Tax ID number of the parent organization of the subsidiary and the names and addresses of any officer or director of the parent organization. This information shall be provided to the state department upon initial licensure and ***changes in the information shall be provided to the state department on an annual basis***. The information shall be made available to the public upon request and shall be included in the public file of the facility.

Continue on the next page

22. Has the applicant received any civil penalties other than penalties imposed under Health and Safety Code, Section 1424?

23. If the facility is operated by, or proposed to be operated under, a management contract, the names, addresses, and Federal Employer's Tax ID number of any person or organization, or both, having an ownership or control interest of five percent or more in the management company shall be disclosed to the state department. This provision shall not apply if the management company has submitted an application for licensure and complied with paragraph (1), Health and Safety Code, Section 1267.5(a)(3).

24. Provide evidence satisfactory to the department(s) that the applicant to operate a skilled nursing or intermediate care facility possesses financial resources sufficient to operate the facility for a period of at least 45 days.

25. On and after January 1, 1990, no person may acquire a beneficial interest of five percent or more in any corporation or partnership licensed to operate a skilled nursing or intermediate care facility or in any management company under contract with a licensee of a skilled nursing facility, intermediate care facility, or residential care facility for the elderly, nor may any person become an officer or director of, or general partner in, such a corporation, partnership, or management company without the prior written approval of the state department.

26. Area health planning approval: (if required)

Date of application: _____ Date of approval: _____Capacity approved:_____

27. I (we) accept responsibility to:
   A. Comply with local ordinances concerning zoning, sanitation, building and other appropriate ordinances.
   B. Comply with the Labor Code on employment practices concerning nondiscrimination, liability insurance, wages, hours, and working conditions.
   C. Comply with Health and Safety Code and regulations concerning licensing and fire safety.

I (we) declare under penalty of perjury that the statements on this application and on the accompanying attachments are correct to my (our) knowledge.

Signed _____ Title _____ Date _____

Signed _____ Title _____ Date _____

Signed _____ Title _____ Date _____

Signed _____ Title _____ Date _____

28. Do you wish to apply for the Medicare program? ☐ Yes ☐ No

29. Do you wish to apply for the Medi-Cal program? ☐ Yes ☐ No

30. **CIVIL AND CRIMINAL RECORD**

☐ Yes ☐ No Have you or any officer, director, shareholder with a beneficial interest exceeding 10 percent, or person in charge of the facility, ever been convicted of an offense other than minor traffic violations?

☐ Yes ☐ No Has there been a judgment against you or any officer, director, shareholder with a beneficial interest exceeding 10 percent, or person in charge of the facility, for fraud, misrepresentation, libel, or slander?

☐ Yes ☐ No Were you or any officer, director, shareholder with beneficial interest exceeding 10 percent, or person in charge of the facility, ever voluntarily committed or involuntarily detained in any facility or institution?

(If you answered "Yes," to any of the above, please explain. Use additional sheets, if necessary.)

31. **RELEASE OF INFORMATION STATEMENT**

The information provided on this form is mandatory and is necessary for licensure approval. It will be used to determine individual applicants or applicant facility's ability to provide health services. The information is requested by the Department of Health Services, Licensing and Certification, in accordance with Health and Safety Code, Sections 1212, 1253, 1265, 1267.5, and 1728, and California Code of Regulations (CCR), Title 22, Sections 70107, 71107, 73205, 74105, 76205, and 78205.

Failure to provide the information as requested may result in nonissuance of a license or license revocation.

The information is considered public information and will be made available to the public upon request. The information shall be included and maintained in the individual facility's public files located in Licensing and Certification district offices.

A LIMITED LIABILITY COMPANY is required to provide the following additional information: Articles of Incorporation, Operating Agreement (if one exists), current list of each member and holder of economic interest and their contribution and share, current list of any manager(s), Secretary of State filing statement under Corporation Code Section 17060, and Company Officers. (Please use attachments.)

INSTRUCTIONS FOR APPLICATION FOR FACILITY LICENSE

Type or print clearly. Prepare application in duplicate. Return original and maintain a copy for your records. Attach with the application a copy of forms and documents underlined below.

1. **Applicant(s)**: Enter the legal person(s) or organization responsible for the facility. Enter full names. Individuals enter first, middle, and last name. Husband and wife, if joint applicants, both sign. Individuals, each partner, principal officers of corporations, and limited liability companies must complete *Applicant Information* (HS 215). Corporations, other business entities, and other organizations must also complete Administrative Organization (HS 309).
2. **Check type**: Self-explanatory.
3. **Applicant address**: Enter home address of individual and corporations. Major partner—enter home address. Other partners enter home address on Applicant Information. Enter area code with telephone number.
4. **Facility name**: Enter the name used to designate the single facility under application. If an agency, fill in the name of the agency which provides the services.
5. **Facility location**: Enter the physical location of the facility. If facility is difficult to locate, add directions for reaching facility under Additional Space. If applicant has more than one facility, a separate application must be completed for each facility. Enter area code with telephone number.
6. **Facility mailing address**: Self-explanatory.
7. **Person in charge of facility**: Enter the name of person who will directly supervise the facility. If not yet employed, enter "unknown."
8. **Type of application**: Self-explanatory.
9. **Type of facility**: Enter the title used in law and regulations. If unknown, enter the name commonly used to identify such facilities.
10. **Amount of *fee* enclosed**: Enter the amount of money enclosed with this application. If no fee is now involved, enter "none."
11. **Requested capacity**: Enter the total number of persons for whom care will be provided in any 24-hour period.
12. **Age range**: Enter age range of persons receiving care.
13. **Time of operation**: Enter hours and days of operation of facility.
14. **Was facility previously licensed**: Self-explanatory.
15. Is facility to be constructed or require major building change: Self-explanatory.
16. **Property ownership**: Applicant must show evidence of control of property. If property is owned, enclose copy of *Deed, Bill of Sale.* If property is leased, enclose copy of *lease agreement.*
17. Submit names as requested with Federal Employer's Tax ID number.
18. Submit names and addresses as requested.
19. List names and addresses of facilities in and out of California.
20. Provide list if applicable.
21. Provide names and addresses upon initial licensure and any changes to this information annually. Include Federal Employer's Tax ID number.
22. Provide information concerning civil penalties other than those imposed under Section 1424, Health and Safety Code.
23. List names and addresses as requested.
24. Submit evidence as described.
25. Note date and condition of beneficial interest.
26. **Area health planning approval**: Health facilities are required to complete and submit Area Health Planning Approval (HS 108).
27. **Statement of responsibilities, signatures**: Application must be signed by applicant or authorized person(s).
28. For health facilities that want to be certified for Medicare. All other applicants check "No."
29. For health facilities that want to be certified for Medi-Cal. All other applicants check "No."
30. Indicate specific civil and criminal record information.
31. Submit information as requested.